

Safe Start for Long Term Care Recommendations and Requirements:

Adult Family Homes, Assisted Living Facilities & Enhanced Services Facilities

July 1, 2021 Updates to the Safe Start for LTC Recommendation and Requirements Document.

1. The information contained in this Safe Start for Long Term Care (LTC) document is independent of any other Washington state reopening guidance.
2. Facilities and homes are required to follow these Safe Start for LTC Recommendations and Requirements.
3. The impact of COVID-19 vaccines on community transmission rates may allow for future changes to the recommendations and requirements in the Safe Start for LTC.

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Introduction

Safe Start for Long-Term Care (LTC) Facility Recommendations and Requirements

The Department of Social and Health Services (DSHS) and the Department of Health (DOH) are presenting the updated safe start plan for licensed and certified long-term care facilities and agencies. Given the critical importance of limiting COVID-19 exposure in long-term care residential care settings and certified supported living agencies, decisions on relaxing restrictions are made:

1. With careful review of various unique aspects of the different facilities and communities in which they reside;
2. In alignment with the Governor's Proclamations; and
3. In collaboration with state and local health officials.

This approach will help keep residents and clients healthy and safe.

Because the pandemic is affecting communities in different ways, DSHS, DOH and the Governor's Office regularly monitor the factors for the Safe Start for LTC and adjust the Washington plans accordingly.

Residential Care Setting and safe start Requirements

1. *Follow the Centers of Disease Control and Prevention (CDC) Department of Health (DOH) and local health jurisdictions' (LHJs) (when applicable) infection control guidelines to slow COVID-19 spread*

2. *Cooperate with the local health officer or his/her designee in the conduct of an outbreak investigation, including compliance with all recommended or ordered infection prevention measures, testing of staff, and testing of residents.*
3. *Follow this DSHS and DOH Safe Start for LTC plan. This document is guidance for LTC and is not included in any other Washington State reopening plan.*
4. *Individual facility types have state statute or rules that requires a facility to impose actions to protect the residents by activating their infection control plan.*
5. *The LHJ or DOH have the authority to return a facility to more restrictive operations in response to any infectious disease and/or COVID-19 outbreak.*
 - *Examples that may require a facility to return to more restrictive operations include but are not necessarily limited to new outbreaks of COVID-19 in their facility as determined by the LHJ or DOH. The LHJ and DOH under WAC 246-101-505 and WAC 246-101-605 have the authority to conduct public health investigations and institute control measures and, pursuant to WAC 246-101-305, LTCs are obligated to cooperate with these investigations. Please refer to the DOH definition of an outbreak found here: [Interim COVID-19 Outbreak Definition for Healthcare Settings](#)*

All facilities and agencies must be prepared for an outbreak and make assurances they have;

1. The facility must maintain access to COVID-19 testing for all residents and staff:
 - a. Aiming for fast turnaround times, ideally less than 48 hours,
 - b. Testing all clients with signs and symptoms of COVID-19 or has exposures,
 - c. Working with local and state public health to coordinate repeat and outbreak testing, and
 - d. Capacity to conduct ongoing, serial testing of clients and staff according to federal, state and local guidance;
 - e. Testing includes point of care antigen testing and PCR lab testing.
2. A response plan outlining cohorting and other infection control measures.
3. A plan to actively screen all staff following the symptom screening strategies that can be found here: [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\) | CDC](#) and to screen all visitors using the [DOH Supplemental Guidance for Long-term Care Facility Visitors](#).
4. Dedicated space for cohorting and managing care for residents with COVID-19 or if unable to cohort residents, have a plan which may include transferring a person to another care setting.
5. A plan in place to care for residents with COVID-19, including identification and isolation of residents. The home/facility or agency plan describing the identification, care and isolation of residents or clients may be requested by DSHS, DOH or the LHJs to conduct an outbreak investigation. Technical assistance for development of these plans can be received from LHJs.
6. Protected and promoted resident and client rights while following standards of infection control practices including when a resident or a client requires quarantine or isolation due to individual disease status or an outbreak in a residential facility or client home.

[Core Principles of Safe Start and COVID-19](#)

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for long-term-care, and should be adhered to at all times. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglas dividers, curtains). Also, providers should enable visits to be conducted with an adequate degree of privacy whenever possible. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. Providers may restrict or limit visitation due to facility/home COVID-19 status, a resident's COVID-19 status, visitor symptoms, visitor lack of adherence to proper infection control practices, or other relevant factors related to the COVID-19 public health emergency. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance:

[Personal Protective Equipment \(PPE\)](#)

Providers will ensure visitors and those providing compassionate care wear proper source control (e.g., well-fitting cloth mask or facemask) at all times when moving about the facility. Visitors and those providing compassionate care will continue to wear source control during the indoor visit in the resident room or designated visiting area or during outdoor visits if either the resident or visitor is not fully vaccinated or the vaccination status of either party is unknown. Visitors will wear all PPE recommended when indicated by standard or transmission based precautions. Facilities have the flexibility to safely manage visitation and may deny a visitor access if they are unwilling to wear appropriate PPE. If the visitor is denied access, they will be given the [Regional Long-Term Care Ombuds](#) or the [Developmental Disability Ombuds](#) contact information (or both if appropriate to the situation), and Local Health Jurisdiction contact information. They must also be given information regarding the steps they can take to resume the visits, such as agreeing to comply with infection control practices and Washington Safe Start Guidelines. For additional guidance, see [Contingency Strategies for PPE use during COVID-19 Pandemic](#)

All staff and essential personnel, must wear appropriate [source control](#) or PPE when they are interacting with residents, to the extent PPE is available, and in accordance with [CDC PPE optimization strategies](#). If the county case count is greater than 25 per 100,000, staff must wear eye protection for all resident encounters. [County Case Counts](#)

For additional guidance, refer to DOH PPE chart located at [Contingency Strategies for PPE use during COVID-19 Pandemic](#) and [DOH/L&I Respirator and PPE Guidance for Long-Term Care](#).

[Adult Family Homes providers and staff who live in the home](#) may utilize the following strategies when in areas of the home residents do not gather:

- If the provider/staff have a separate living area that is not a part of the adult family home, they do not need to apply the AFH source control and PPE strategies in their private living space. They may have visitors in this space and follow the CDC guidance for the general public in this area.
- If their personal bedroom is located in the licensed portion of the home, but residents do not enter, the provider or staff do not need to apply source control and PPE strategies in that room;

- If the provider/staff are alone in a room of the home and there is a limited chance residents or other staff will enter the space (i.e. residents are on an outing or in bed, no other staff are on duty, residents have limited mobility) the provider/staff does not need to apply the AFH source control and PPE strategies at that time.
- If the provider has family or friends who visit a licensed area of the home (and do not live in the home), their visitors will need to wear source control and maintain social distancing from any unvaccinated residents.

Screening

- Active screening must continue regardless of vaccination status
- Actively screen residents daily.
- Actively screen 100% of all persons (residents, staff, visitors, etc.) entering/re-entering the facility/home including: temperature checks, questionnaire about symptoms and potential exposure, observation of any signs or symptoms, and ensure all people entering the facility or home have cloth face covering or face mask.
- Maintain a screening log for 30 days.
- Do not screen EMTs or law enforcement responding to an emergent call.

Infection Prevention

Infection prevention should entail the following basic concepts, at a minimum:

- [Active screening](#) of all who enter the facility/home for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose), and use of eye protection if appropriate
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces in the facility/home often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care) if possible

Access to Ombuds and Resident Right Advocates

Washington State laws and rules provide representatives of the Office of the State Long-Term Care Ombudsman and the Developmental Disabilities Ombuds with immediate access to any resident. During this public health emergency, in-person access may be limited due to infection control concerns and/or transmission of COVID-19; however, in-person access may not be limited without reasonable cause. We note that representatives of the Ombuds should adhere to the core principles of COVID-19 infection prevention. If in-person access is not advisable, such as the Ombuds or the resident having signs or symptoms of COVID-19,

facilities must, at a minimum, facilitate alternative resident communication with the ombuds, such as by phone or through use of other technology. Providers will work with Ombuds to coordinate and identify private meeting space that meets infection controls standards if visitation in the resident's room is not possible.

Federal and State Disability Laws

Providers must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility/home must allow the individual entry into the facility/home to interpret or facilitate, with some exceptions. This would not preclude facilities/homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention.

Personnel

Medically Necessary Providers, Service and Health Care Workers Principles

- Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after an active screening process. We note that EMS personnel do not need to be screened so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.
- Review Provider letter [20-062](#), regarding who is allowed into the facility/home at all times
- Essential healthcare personnel such as Nurse Delegators will follow DOH guidance for nurse delegation.

Non-Healthcare Personnel

- All non-healthcare personnel are allowed in the building if the facility/home is not in outbreak status. If the facility/home has cohorted COVID positive residents to one unit and the rest of the building is open, the non-healthcare personnel may visit areas not in outbreak status. Because non-healthcare personnel have the potential for contact with unvaccinated staff or residents, they must wear source control and physically distance at all times while in the building regardless of their own vaccination status.
- The Beautician/Barber/Nail Technician must have a designated space.

Communal Activities and Dining Principles

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. The facility/home must utilize the following criteria to determine the best approach to communal activities and dining:

Who must not participate in communal activities?

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- Vaccinated and unvaccinated **residents with SARS-CoV-2 infection, or in isolation because of suspected COVID-19**, until they have met [criteria to discontinue Transmission-Based Precautions](#).
- Vaccinated and unvaccinated **residents in [quarantine](#)** until they have met criteria for release from quarantine.

What infection prevention and control practices are recommended when planning for and allowing communal activities?

Determining the vaccination status of residents/healthcare professional (HCP) at the time of the activity might be challenging and might be subject to local regulations. When determining vaccination status, the privacy of the resident/HCP should be maintained (e.g., not asked in front of other residents/HCP). For example, when planning for group activities or communal dining, facilities might consider having residents sign up in advance so their vaccination status can be confirmed and seating assigned. **If vaccination status cannot be determined, the safest practice is for all participants to follow all recommended infection prevention and control practices including maintaining physical distancing and wearing source control.**

- *Group activities:*
 - If all residents participating in the activity are fully vaccinated, then they may choose to have close contact and to not wear source control during the activity.
 - If unvaccinated residents are present, then all participants in the group activity should wear source control and unvaccinated residents should physically distance from others.
- *Communal dining:*
 - Fully vaccinated residents can participate in communal dining without use of source control or physical distancing.
 - If unvaccinated residents are dining in a communal area (e.g., dining room) all residents should use source control when not eating and unvaccinated residents should continue to remain at least 6 feet from others.
- *“Cohort” activities/dining based on vaccination status:*
 - The facility/home may host separate activities/dining based on vaccination status
 - The facility/home must ensure that they continue to comply with Resident Rights requirements

Offsite Visits and New Admissions

Providers must use the [Risk Assessment Template](#) to assess each resident for any COVID-19 exposure after returning from offsite visits to determine if the resident is low or high risk. Automatic quarantine should not be the standard practice upon returning from a trip into the community. Decisions about precautions taken with a resident as a result of the assessment must be documented in the resident’s care plan.

- For medically and non-medically necessary trips away from of the facility:
 - The resident must be encouraged to wear a cloth face covering or face mask when the trip will involve entering spaces where source control is still required unless medically contraindicated; and
 - The facility must share the resident’s COVID-19 status with the transportation service and entity with whom the resident has the appointment.
 - Transportation staff, at a minimum, must wear source control. Additional PPE may be required.
 - Transportation equipment shall be sanitized between transports.

- Residents can make trips outside of the building and into the community, including non-medically-related trips, to locations that are open to the public. However, residents are encouraged to limit or avoid trips where appropriate precautions are not being followed.
 - Adult Family homes please see Dear Administrator letter [AFH 020-027](#) for details regarding residents leaving the facility for non-medically necessary trips.
 - Assisted Living Facilities please see Dear Administrator Letter [ALF 020-028](#) for details regarding residents leaving the facility for non-medically necessary trips.
 - Enhanced Services Facilities Please see Dear Administrator Letter [ESF 020-021](#) for details regarding residents leaving the facility for non-medically necessary trips.

Provide a letter to Families and residents outlining potential risks involved in community activities when residents/clients are preparing for an outing. Upon the resident return to the facility/home complete a risk assessment. Both the letter and the assessment can be found here: [Risk Assessment Template to Assess COVID-19 Exposure Risk and letter to Resident/Clients and Families](#)

If the resident/client or family has already reviewed the risk letter for previous outings, it is not necessary to provide a new letter with each trip into the community unless the information has changed.

A home should use the [Interim Guidance for Transferring Residents between Long-Term Care and other Healthcare Settings](#) to determine if a newly admitted resident would require a quarantine. This guidance takes into account the vaccination status of a resident, along with other mitigating factors.

Negotiated Service Agreement/**Negotiated Care Plan**

Because person-centered care is key, providers will document in the resident care plan medically necessary care, compassionate care, and designated person care delivery.

Continuing Care Retirement Communities (CCRC) and Independent Living Campus

State licensed homes that reside on the same campus as CCRCs and independent living settings, must follow these Safe Start Long Term Care Recommendations.

Holiday Guidance

Providers should follow CDC guidelines for holidays. Where State or LHJ guidance provides stricter measures, providers must follow the stricter guidance. This guidance does not replace state proclamation requirements, DOH, and CDC link: <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/holidays.html>. Providers must follow all guidelines for visitation within this document with strict adherence to infection control principles to prevent the spread and transmission of COVID-19.

Key Visitation Principles

Visitation can be conducted through different means, based on a facility/home's structure, community virus activity, and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, through the use of remote technology, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission.

All facilities and agencies are required to provide accommodations to allow access for in person visitation for all residents and clients, within the guidelines outlined below. If State or LHJ guidance is stricter, the stricter guidance must be followed. Each facility must have a written visitation protocol and it must be shared with visitors who agree to abide by the protocol. Any equipment shared among residents should be cleaned and disinfected between uses according to manufacturer guidelines.

Visitation will be accommodated when such visits are by phone, remote video technology, window visits.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred *even when the resident and visitor are fully vaccinated* against COVID-19*. Outdoor visits *generally* pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations or an individual resident's health status may hinder outdoor visits. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to. [Outdoor Visitation Guidance for Long-term Care Settings](#)

**Fully vaccinated refers to a person who is ≥ 2 weeks following receipt of the second dose in a 2-dose series, or ≥ 2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.*

Outside Safety Related to Structures

Providers must follow state fire marshal requirements for safety related to tent use or other temporary shelter structures: proper installation and suitable anchoring, flame resistant product use, protection of residents, tents, and surrounding grounds must be free of combustible materials, not obstruct fire hydrants, smoke free and equipped with smoke free signs, comfortable temperatures, fire marshal approved only heater use, no open fires/flames within or around tents, fire marshal approved only lighting sources, clear unobstructed path for egress, easily opened doors and zippers, hard packed walking surfaces with no tripping hazards, and illumination of operating in dark hours. Providers must ensure resident wear proper clothing for outdoor climate, and promote outside safety and comfortable temperatures via a structured shelter, parking lot, patio, or courtyard venue.

Indoor Visitation

Facilities should allow indoor visitation for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. **Compassionate care visits should be permitted at all times**, including during the times outlined below when regular visitation is curtailed. These scenarios for limiting indoor visitation include:

- Unvaccinated residents, if the facility COVID-19 county positivity rate is >10% **and** <70% of residents in the facility are fully vaccinated;
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; or
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

How do I determine visitation status for unvaccinated residents?

To determine if unvaccinated residents are able to have visitors, follow the pathway below:

- 1) Is your facility in a county where the positivity rate is less than 10%? Check [here](#).

If yes, indoor visits may occur with core infection prevention principles in place.

If no, go to #2.

- 2) Is the resident vaccination rate in your facility greater than 70%?

(To determine vaccination rate – take number of residents fully vaccinated and divide by total number of residents in the home then multiply this number by 10. For example:

7 vaccinated residents divided by 10 total residents = 0.7

0.7 multiplied by 10 = 70% vaccination rate)

If yes, indoor visitation may occur with core infection prevention principles in place.

If no to both, then indoor visits should be limited to compassion care visits for residents who are not fully vaccinated.

- The facility/home must establish policies and procedures outlining how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. The facility must also take into consideration work schedules of visitors and include allowances for evening and weekend visits.
- The facility will post at the entrance, and with the visitor log, vaccination requirements for visitation, as well as a notice that it is a violation of the Governor's Proclamation for visitors to visit unvaccinated residents under certain circumstances.

- The Facility/home must establish policies and procedures around tours of the home for the purpose of screening for prospective new residents. The policies and procedures should include when tours will occur, screening process before entry of visitor(s) into the home, movement about the facility during the tour, and adherence to core principles of infection prevention.
- If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors.
- During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area.
- Visitors must be actively screened upon using the [DOH Supplemental Guidance for Long-term Care Facility Visitors](#). Those with symptoms or recent exposure will be denied entry.
- Visitors must sign in, including contact information, in a visitor's log. Visitors must acknowledge they have reviewed the notice about the Governor's Proclamation related to visitation an unvaccinated resident in certain circumstances. The log of visitors must be kept for 30 days. **
- Visits for residents who share a room should not be conducted in the resident's room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.
- If both the resident and the visitor are fully vaccinated, while alone in the resident's room or the designated visitation area, residents and their visitor(s) can choose to have close contact (including touch) and to not wear source control. The resident and visitor may also eat together in the private area.
- If either the resident or the visitor has not been fully vaccinated, the safest approach is for the resident and their visitor to maintain physical distancing (maintaining at least 6 feet between people). If the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing well-fitting source control.
- When moving about the facility and during encounters with staff or residents other than the person they are visiting, the visitor must wear source control.
- Visitors and residents should practice hand hygiene before and after the visitation.

Indoor Visitation during an Outbreak

An outbreak exists when a new facility/home onset of COVID-19 occurs that meets the outbreak definition found here: [Interim COVID-19 Outbreak Definition for Healthcare Settings](#). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 can be contained to a single area (e.g., unit) of the facility/home or the LHJ is able to assist with recommendations, dependent on the setting:

<p>Assisted Living Facility (ALF), Enhanced Services Facilities, and Adult Family Homes with the ability to contain an outbreak to a unit or area</p>	<p>Adult Family Home (AFH), Enhanced Services Facility (ESF), and Assisted Living Facilities (ALF) without the ability to contain positive cases to a unit or area of the building</p>
<p>When a new case of COVID-19 is identified and the facility meets the outbreak definition found in the Interim COVID-19 Outbreak Definition for Healthcare Settings, a facility should immediately work with the LHJ to begin outbreak testing and suspend all visitation until at least one round of facility-wide testing is completed.</p> <p>Visitation can resume based on the following criteria:</p> <ul style="list-style-type: none"> • If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases. <ul style="list-style-type: none"> ○ Outbreak testing is discontinued when testing identifies no new cases of COVID-19 infection among staff or residents for at least 14 days since the most recent positive result • If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then the facility should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing. <p>Compassionate care visits should be allowed at all times, for any resident (vaccinated or unvaccinated) regardless of the above scenarios.</p> <p>Window visits and visits using technology are not restricted or prohibited. Providers will permit window visits depending on grounds safety, resident privacy and choice, and facility capacity, case mix,</p>	<p>When a new case of COVID-19 is identified and the facility meets the outbreak definition found in the Interim COVID-19 Outbreak Definition for Healthcare Settings, a facility/home should immediately work with the LHJ to begin outbreak testing and suspend all visitation until at least one round of facility-wide testing is completed.</p> <p>Visitation can resume based on criteria determined through coordination between the facility/home and the LHJ.</p> <p>Compassionate care visits should be allowed at all times, for any resident (vaccinated or unvaccinated) regardless of outbreak status.</p> <p>Window visits and visits using technology are not restricted or prohibited. Providers will permit window visits depending on grounds safety, resident privacy and choice, and facility capacity, case mix, and staffing. Providers will also assist with the use of technology to support continued social engagement during an outbreak.</p> <p>In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.</p>

and staffing. Providers will also assist with the use of technology to support continued social engagement during an outbreak.

In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

A facility should continue to consult with their LHM when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.

Compassionate Care Visits:

While end-of-life situations have been used as examples of compassionate care situations, the term “compassionate care visits” does not exclusively refer to end-of-life situations. Examples of other types of compassionate care visits include, but are not limited to:

- A resident, who was living with their family before recently being admitted to a facility and is struggling with the change in environment and lack of physical family support.
- A resident who is grieving the recent loss of a friend or family member.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations would be consistent with the intent of, “compassionate care visits.” Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident’s needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included.

At all times, visits should be conducted using social distancing and visitors will wear PPE appropriate to the situation. Visitors should coordinate visits with the provider, thus allowing the provider the ability to take the compassionate care visit into consideration when applying the facility policies and procedures for visitation during that period of time (i.e. how many people overall are in the building, how long visitors are in the building, how much PPE is required). If during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines, and for a limited amount of time. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.

****[Visitor Log Information](#)**

Visitor's log information will include date, time in, name of visitor and their contact information, including phone number and email address if available.

[Additional Resources](#)

Outbreak Definition

[Interim COVID-19 Outbreak Definition for Healthcare Settings](#)

Influenza vs COVID-19

[CDC Similarities and Differences between Flu and COVID-19](#)

[Interim Guidance for Transferring Residents between Healthcare Settings](#)

[Risk Assessment Template](#) (quarantine for the purpose of this document is per template context)

Indoor/Outdoor Visitation Guidance

[Outdoor Visitation Guidance](#)

LHJ and DOH Assessment Teams

Consider an onsite or virtual LHJ/DOH COVID-focused Infection Control Assessment. This is a non-regulatory support to enhance facilities' internal infection control program.